Recommended Resources

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Appendix A

Recommended Resources

Michelle Davis, Provincial Resource Teacher at Peak House recommends the following resources:

Helping Schools *– The Centre for Addictions Research of BC, University of Victoria*

Resources designed to help educators and other adults in the school community stimulate students to think differently about drugs and to explore the meaning of drugs in human experience. This resource is grounded in a social ecological model of public health and it encourages schools to recognize, explore and address the social and environmental factors – not just individual factors- that influences students' health and learning, particularly those factors relates to drug use. The Centre for Addictions Research of BC is happy to provide consultation to support schools, districts, and parent organizations. Contact carbcvan@uvic.ca for more information

- Instructional resources: ***iMinds*** **–** Drug and gambling literacy curriculum, philosophical inquiry andx constructivist methods in drug education, etc.
- School Policy Resources: Alternatives to suspension, developing healthy drug policies, foundational theory, etc.
- Support for parents and communities: A parent's guide: Youth Cannabis Use, Quick Guide to Drug Use, etc.
- Screening and brief intervention tools: Art of motivation, Guide to peer mentoring, etc.

Alcohol and Drug Information & Referral Service. *HealthLinkBC*

Information, options and support, along with referral to a full range of counselling and treatment services across BC. Contact toll-free at 1-800-663-1441, or in the lower mainland at 604-660-9382. Services are confidential, free, multilingual and available 24/7.

HeretoHelp **–** *BC Partners for Mental Health and Addictions Information*

Resources to help people live well and prevent and manage mental health and substance use problems.

You and Substance Use Workbook: Stuff to think about…and ways to make changes**.** (2011) *Centre for Addictions Research of BC*

A workbook for youth with information and guided activities to think about their own substance use, learn where to go if they need more help, harm reduction strategies, and de-stigmatize substance use by considering the ways drugs have the potential to help and harm and harm reduction strategies.

The Art of Motivation **–** *Centre for Addictions Research, University of Victoria*

This online resource is for school professionals and other adults who want to help students avoid drug problems and other obstacles to reach their full potential. It applies the principals of motivational interviewing to support positive behaviour change and engage students in conversations that keep them moving in a forward direction.

Toward the Heart *– BC Centre for Disease Control*

This project aims to reduce harm by empowering and supporting people that are engaging in high risk behaviour to be safer and healthier by providing information about overdose prevention and response and a free online naloxone training course.

Visions: BC's Mental Health and Addictions Journal

An award-winning quarterly magazine that brings together many views on mental health and substance use. You can explore past publications on topics of culture, health literacy, LGBT, cannabis, concurrent disorders, tobacco, families and crisis, trauma and victimization, Aboriginal people, schools, eating disorders, etc.

Schools Issue. (2009) Vol. 5 No. 2

This publication provides alternatives and approaches, experiences/perspectives and information about regional programs.

Substance Abuse in Canada: Youth in Focus**.** (2007) *Canadian Centre on Substance Abuse (CCSA)*

This publication looks at the issue of youth substance use and addiction in Canada from several perspectives: substance use and harm in the general youth population, issues among non-mainstream youth, the "four pillars" of Canada's response (prevention, treatment, enforcement and harm reduction), a neuroscience perspective, and gaps in approach.

Stop Stigma. Save Lives *– Northern Health*

Northern Health has developed a number of resources as part of their *Stop Stigma. Save Lives.* project. By sharing 12 stories of people with firsthand or family experience of drug use, the goal is to reduce stigma by building compassion and empathy.

Trauma-Informed Practice Guide. (2013) *BC Provincial Mental Health and Substance Use Planning Council*

This guide and included organizational checklist is intended to support the translation of trauma-informed principles into practice by providing concrete strategies. The goal of TIP is to build on what is already working for practitioners and programs and to refine existing practices and teach a trauma-informed approach.

Creating Sanctuary in the School. (1995) by Sandra L/ Bloom, M.D.

This article discusses a "group consciousness" that is required for staff to effect major change for students by redirecting traumatic scenarios to ensure trauma is not repeated. Traumatized children benefit from adults that can extent the vital relational skills and a system that provides safety and security for these relationships to be sustained.

Mental Health Resources:

AnxietyBC

A website with online, self-help and evidence-based resources for children, youth, adults, families and educators. The organization also offers information sessions, professional seminars and workshops throughout the year.

AnxietyBC for Youth

A website for youth with interactive content and videos covering anxiety 101, common problems, strategies, quizzes etc.

MindShift App for iPhone and Android *– Anxiety BC, BC Children's Hospital and RBC Children's Mental Health Project*

An app designed to help teens and young adults cope with anxiety. It includes strategies to deal with everyday anxiety, and specific tools to tackle: sleep, emotions, test anxiety, perfectionism, social and performance anxiety, worry, panic, conflict.

Keys to Unlocking Depression: *An Internationally Known Depression Expert Tells You What You Need to Know to Overcome Depression.* (2016) by Michael D. Yapko, PhD.

A book of 50 statements in an easy to read format that gives essential information about depression and provides readers with perspective about how to think about depression, which greatly influences ones' experience of depression.

Stopping the Noise in Your Head: The New Way to Overcome Anxiety and Worry. (2016) by Ried Wilson

A book of strategies to shift perspective by confronting anxiety head-on and stepping into challenges.

My Anxious Mind: A Teen's Guide to Managing Anxiety and Panic. (2009) by Tompkins

A book that outlines a simple and proven plan to help youth understand and deal with their anxiety and panic.

The Anxiety Workbook for Teens: Activities to Help You Deal with Anxiety and Worry. (2008) by Lisa M. Schab

A workbook of activities for youth to support anxiety management and prevention. Great for younger teens.

Mental Health & High School - Curriculum Guide. Version 3 (2017) Teenmentalhealth.org

A universal intervention teaching program for all students to reduce stigma, teach mental health literacy and self-help skills.

When Something's Wrong – Strategies for Teachers. (2007) Canadian Psychiatric Research Foundation

A quick reference handbook for teachers to understand and implement ways to support children with mental health disorders. The handbook is made up of independent sections: anxiety disorders, autism, depression, eating disorders, impulse control disorders, schizophrenia, and Tourette syndrome. For more information and additional strategies, see the second handbook ***When Something's Wrong: Ideas for Families*** which contains sections on PTSD, borderline personality disorder, bipolar affective disorder, suicide, and working with the health practitioner.

Teaching Students with Mental Health Disorders – Vol 2 - Depression, Resources for Teachers. (2001) BC Ministry of Education.

Social Emotional & Resiliency

Growing Up Resilient – Ways to build resilience in children and youth. (2007) by Tanyana Barankin & Nazilla Khanlou.

This book has received awards and is recommended as a reference for educators who want to increase resilience in children and youth. The author considers the development of resilience at three levels: individual, family & environmental.

Grief and Loss Resources ***– Living Through Loss.*** Counselling Society of BC.

Counselling, training, support groups and resources: self care advice, articles, books and videos, grief during holidays, links for helping with community grief and tragedy.

Strong Teens Strong-Teens-Grades 9-12*: *A Social & Emotional Learning Curriculum. (2013) by Kenneth W. Merrill

This 12-week program is a universal teaching intervention for all students with classroom activities of partially scripted lessons, handouts and worksheets where students learn about emotions and social-emotional skills. Topics include: dealing with anger, clear thinking, reducing stress, solving interpersonal problems, positive living, and creating SMART goals.

***Teaching Students with Learning and Behavioural Differences, A Resource Guide for Teachers*.** (2006/07) BC Ministry of Education.

***Reaching Teens: Strength-Based Communication Strategies to Build Resilience and Support Health Adolescent Development*.** (2014) by American Academy of Pediatrics

This text and video resource shows professionals strength-based communication approaches. Topics: connection and communication principles, empowering change, supporting parenting, serving special populations, self-care for providers.

For Parents, Caregivers and Families

Recognizing Resilience: A Workbook for Parents and Caregivers of Teens Involved with Substances. (2016) *Kelty Mental Health.*

This workbook is for parents and caregivers of teens who may be experimenting with or regularly engaged in substance use and is intended to move the focus from "the problem" into a discussion of hope. It provides tips on setting boundaries, dealing with aggression and crisis, information about the types of support, resources and treatment options and tips for parents and caregivers while the youth is attending residential treatment. This workbook also provides information about adolescent development, why youth may use substances, strategies for nurturing relationships and resilience, and opportunities for self-reflection on values, beliefs, attitudes, substance use and parenting.

***The Coping Kit: A guide for family members*.** *From Grief to Action (FGTA): When addiction hits home*

Written by family members for family members, the Coping Kit provides an overview of a wide range of information and resources that are relevant to the difference stages of substance use and addiction. This resource also contains Parents in Action: A guide for setting-up and running a support group.

Quick Guide to Drug Use. *Centre for Addictions Research of BC, University of Victoria*

This one-page hand-out discusses why people use drugs, how using a drug can be good and bad, and the factors that contribute to the level of risk.

Parenting: The Drugs Question. *(2016) Helping Schools. Centre for Addictions Research of BC. University of Victoria*

This publication contains ten important tips parents/caregivers can use to help their children navigate life successfully, including avoiding hard from alcohol and drugs. There is also a list of helpful substance use resources for families.

Cannabis Use and Youth: A parent's guide. *(2012) Here to Help. BC Partners for Mental Health and Addictions Information.*

A resource to help parents weight the risks (and benefits) of cannabis use and put them in perspective within their individual situation. The goal is to offer a thoughtful and honest discussion on cannabis so families can make better decisions within the context of their family.

Let's Talk Dialogue: Community Conversations about Drugs. *(2017) Centre for Addictions Research of BC*

This article discusses how dialogue can help foster safer, healthier communities by creating new understanding so individuals can better work together. The fundamental elements of dialogue, how to nurture dialogue and how dialogue is different from debating are all discussed.

Appendix B

What to Look For - Signs and Symptoms of Substance Use Disorder

The following signs and symptoms are early warning signs that may associated with substance use disorders:

Physical changes and health signs:

- Changes in energy levels (hyperactivity, drowsiness or lethargy)
- Deterioration in personal grooming/hygiene and self-care
- Sudden weight loss or weight gain
- Unusual odor (breath, body, or clothing)
- Changes in appetite or sleep patterns
- Bloodshot eyes and abnormally sized pupils
- Frequent nosebleeds
- Seizures without a history of epilepsy
- Tremors, incoherent or slurred speech, impaired or unstable coordination
- Unexplained injuries, bruises or accidents

Psychological or social signs:

- Change in personality or usual attitude
- Changes in relationships (problems, new friends, hangouts, or hobbies)
- Changes in emotions and self-regulation, such as sudden mood swings, anxiety or worry, disassociation, outbursts, laughing, etc.

Behavioural signs:

- Drop or change in attendance and performance at school
- Decreased level of engagement in school, extra-curricular and/or life activities
- Difficulty focusing
- Legal problems related to substance use
- Unexplained need for money or missing money or valuables
- Engaging in isolating behaviours or avoiding eye contact
- Using perfumes, incense or air freshener to hide the smell of smoke or drugs
- Using eye drops to mask bloodshot eyes and dilated pupils
- Changes in self-determination (independence, decision making, lack of “agency”, etc.)

Adapted from the National Council on Alcoholism and Drug Dependence Inc. (NCADD)

Classrooms that HEAL

DESIGNING SCHOOL SPACES to support mental health

By Diana Mogensen, former Vancouver teacher

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Students were noticeably less anxious and spent more time in the learning center after I applied biophilic design principles to the space. Some, who previously avoided the learning center, gravitated toward it. They seemed less depressed, more productive, animated and refreshed, instead of drained while studying. After stressful therapy sessions with their respective treatment teams, their down time seemed to lessen. Their self-regulation skills and transition back to the learning environment seemed easier.

I SPENT the last 10 years of my career teaching as part of the therapeutic team in the inpatient unit of the Provincial Specialized Eating Disorders Program at BC Children's Hospital, working with vulnerable children and youth and school teams from across BC, aligning my pedagogy with the team's trauma-informed practices. My biophilic design studies made me acutely aware of how classroom environments affect the health, well-being, and academic performance of students. Classroom lighting, colour, plants, materials, air flow, and temperature all affect physical/mental health and can be used to create comforting, nurturing spaces that restore, heal, and inspire.

Hospital staff began to enjoy lunch or quiet breaks in the learning center. One nurse said, "I love coming in here just to sit and think. I feel energized and ready to go back to work after half an hour." The yoga teacher who taught a class in the center noted how the room de-stressed students/patients.

Biophilic design relates to the environmental and conversation movements of the last three centuries and was popularized by Harvard biologist and naturalist E.O. Wilson. Defined as "love of life or living systems," the term was originally coined by social psychologist and humanist Eric Fromm. Biophilic theorists and interior design experts subsequently identified 14 elements to consider when designing interior spaces that would encourage our mind/body systems to respond in healthful ways.

I have witnessed real benefits from applying this theory to my classroom practice. Teachers can also apply biophilic design at home for self-care and to de-stress. ■

Tips to create a nourishing classroom/ school environment

Biophilic theory teaches that interior spaces should connect us with nature in a profound way. The interplay of visual, auditory, and haptic connectors can cement our relationship to interior spaces and support positive learning outcomes.

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A diversity of plant life and textures (biodiversity) addresses students' needs for visual complexity, keeping them engaged with the environment by reminding them of nature. Bring in plants and artistic replications of natural landscapes. Vertical gardens are a space-saving way to produce edibles, or just beautiful foliage.

Open windows to allow fresh air flow when possible. Studies link fresh air to improved cognition. Deep mindful breathing is also helpful!

Consider carefully the mood you want to achieve in your classroom. An art room meant to excite creative processes may have a vibrant palette. A natural palette can be calming. Overstimulating children and youth with bold colour and other stimuli could overwhelm some students, especially those with certain special needs.

Recent research has shown that exposure to daylight can improve academic scores and attendance in a significant number of students.

Inexpensive water features can be strong or whimsical additions to classrooms. Water features that can be seen, heard, and felt provide a haptic component as well as auditory and visual elements.

Biophilic elements have the potential to improve:

- mental agility
- memory
- thinking
- learning
- adaptability
- cognition
- mood
- concentration/focus
- alertness.

And can counter the effects of:

- fatigue
- anxiety
- anger.

Learn more at *https://is.gd/1ULaUL..* ■

Promising Practice Series

Alternatives to Suspension

Suspending or expelling students may seem like a quick way to both solve a problem and send a message that rule-breaking won't be tolerated. But education research consistently shows that high rates of suspension are related to a number of negative outcomes for both suspended students and schools, including elevated rates of school dropout, poor school climate, and low academic achievement (Norden, 2005; Rosch & Iselin, 2010). What is more, increases in suspension rates do not contribute to increased school safety (Skiba, 2004).

Research also suggests that there are various ways to minimize or replace the use of suspensions, keeping students connected and schools safe (Mochrie, 2012). The suggestions below are among the promising practices available to schools seeking alternatives to suspension. Studies show implementing a range of strategies at multiple levels (e.g., administrative, school personnel, individual student) is likely to benefit not only individual students but also the broader school community (Rosch & Iselin, 2010; Skiba, Rausch, & Ritter, 2004).

Practices that Create a Positive School Climate

1. Enhance classroom management by
    a. Collaboratively developing and regulating rules and expectations (i.e., teachers and students are involved),
    b. Acknowledging and rewarding positive behaviours, and
    c. Training teachers in more effective methods of classroom management. (This has been a component in many of the most effective programs, and has been shown to decrease suspension, expulsion, and dropout, reduce teacher burnout, and improve student on-task behaviour and academic achievement.)
2. Establish and foster collaborative relationships with students, parents and other stakeholders to develop ways to
    a. Define consequences so that they are educational (rather than punitive), fair, age-appropriate, and matched to the behaviours that should be changed,
    b. Teach, model, and reinforce appropriate behaviours (e.g., mentoring programs or positive behaviour cards that can be used for free admissions, field trips, dances, and additional privileges), and
    c. Support student needs and use knowledge about these needs to address the root causes of a student's misconduct.
3. Offer conflict resolution training programs (to students, teachers, and administrators) that
    a. Acknowledge that conflict is inevitable and is either helpful or harmful depending on how it is handled and
    b. Identify non-violent practices that change characteristics of the individual as well as characteristics of the environment that contribute to the conflict.
4. Use programs and practices that
    a. Promote resilience and
    b. Teach effective problem-solving and pro-social skills at multiple levels (e.g., student peer mediation programs, curriculum, teaching, administration).

Alternatives to Out-of-School Suspensions

1. Develop a sense of community, and hold students and others accountable. This might include
    a. In-school community service programs (e.g., assisting teachers with preparatory work),
    b. Restitution (having people repair any harm they do), and
    c. Restorative practice (having people restore any damage done to their relationships with peers or school personnel).
2. Reconnect alienated students by
    a. Increasing their connections with school and school personnel,
    b. Encouraging caring relationships between students and teachers (e.g., mentoring students through an advisor/advisee program), and
    c. Matching policies to meet the developmental challenges of students' age (e.g., adolescent challenges include the reliance on peer relationships, asserting autonomy, seeking support from non-parental adults, negotiating their development of a unique identity, and building selfefficacy).
3. Develop disciplinary systems that
    a. Have graduated levels of disciplinary actions matched to the seriousness of the infraction (with suspension being the last alternative reserved for situations in which personal safety cannot be maintained otherwise),
    b. Provide clear definitions of all minor and major behavioural misconduct to all staff and students,
    c. Include individual behaviour plans which tend to be used with students having a disability, but may also be useful in addressing the underlying function of concerning behaviour of nondisabled students, and
    d. Have teachers and personnel who have regular contact with students provide the first point of contact for communicating with parent(s) about disciplinary actions.
4. Provide in-school alternatives such as
    a. Establishing spaces in which students can "cool off" or work privately,
    b. Providing individual counseling or wrap-around teams, and
    c. Requiring before- or after-school detentions or Saturday school.

Note: implementing a data management systems that records student misconduct and disciplinary practices can help guide development of alternative options tailored to disciplinary issues that exist in each school.

References

Mochrie, C. (2012). Keeping Youth Connected, Healthy and Learning: Effective Responses to Substance Use in the School Setting. Victoria, BC: Vancouver Island Health Authority.

Norden, P. (2005). Keeping Them Connected: A National Study Examining How Catholic Schools Can Best Respond to Incidents of Illicit Drug Use. Richmond, Victoria: Jesuit Social Services, Ignatius Centre for Social Policy and Research.

Rosch, J., & Iselin, A.-M. (2010). Alternatives to Suspension. Center for Child and Family Policy, Duke University.

Skiba, R. (2004). Zero Tolerance: The Assumptions and the Facts. Education Policy Briefs, 2(1), 1–8.

Skiba, R., Rausch, M. K., & Ritter, S. (2004). "Discipline is always teaching": Effective alternatives to zero tolerance in Indiana's schools. Education Policy Briefs, 2(3).

Defining Drug Literacy

Drug literacy can be defined as acquiring the knowledge and skills needed to successfully navigate the world in which we live – a world full of drug-related pressures, promises and panaceas. Students need to develop the competencies to survive and thrive in this world.

Drug literacy is built by engaging students in honest, thoughtful discussions and projects that involve issues relevant to their daily lives. The goal is to encourage students to both express and think critically about their current drug-related beliefs, attitudes and behaviours.

A socio-ecological approach suggests that awareness, actions, decisions and behaviours are influenced by multiple factors including personal factors requiring self-awareness and self-management skills, relationships requiring social awareness and skills, and the physical and cultural environments requiring life knowledge and navigational skills.

Therefore, in order to be "drug-literate," students need to learn to …

- assess the complex ways in which drugs impact the health and wellbeing of individuals, communities and societies
- explore and appreciate diversity related to the reasons people use drugs, the impact of drug use and the social attitudes toward various drugs
- recognize binary constructs (e.g., good vs bad) and assess their limitation in addressing complex social issues like drug use
- recognize how official responses to drugs may have less to do with the drug than with other factors
- develop social and communication skills in addressing discourse and behaviour related to drugs
- develop personal and social strategies to manage the risks and harms related to drugs

The drugs of primary interest for our purposes are psychoactive substances—including alcohol, tobacco, some pharmaceutical medications, cannabis and other illegal drugs. However these competencies, with minor modification, could be applied to many aspects of health and wellbeing as they encourage the development of both autonomy and social belonging.

Helping Schools

Drug Literacy Curriculum

Big Ideas (about psychoactive drugs)[1]

People have been using drugs for thousands of years and in almost every human culture.

Drugs can be tremendously helpful and also very harmful.

As humans, both individually and as communities, we need to learn how to manage the drugs in our lives.

We can learn how to control our drug use by reflecting on the different ways people have thought about drugs, exploring stories from various cultures and listening to each other.

Competencies and Content

Students need to learn to …

- assess the complex ways in which drugs impact the health and wellbeing of individuals, families, communities and societies
- explore and appreciate diversity related to the reasons people use drugs, the impact of drug use and the social attitudes toward various drugs

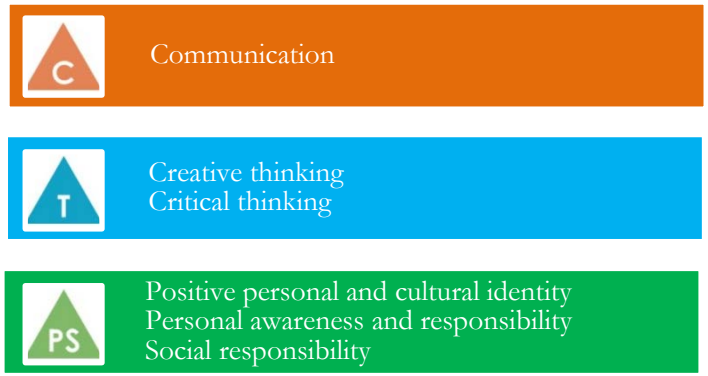
By exploring content such as …

- the place of drug use in different cultures
- the changing ways cultures have interacted with drugs over time
- the various constructs (e.g., social activity, moral weakness, criminal behaviour, disease) used to characterize drug use
- the social, political and health impacts of various patterns of drug use
- the role of individual experience, ideas and agency as they impact attitudes and behaviours related to drug use
- the relationship between political, economic and social factors related to drug use and drug policy
- the relationship of inequity to the harms related to drug use
- the role of political priorities in shaping drug use patterns and outcomes

[1] Psychoactive drugs (i.e., mind-altering substances), including caffeine, alcohol, cannabis and a wide range of other drugs, tap into the wiring system of the human brain and impact the way nerve cells send, receive or process information thus influencing the way we think, feel or behave.

Students need to learn to …	By exploring content such as …
• recognize binary constructs (e.g., good vs bad) and assess their limitation in addressing complex social issues like drug use	• the interconnected relationship of personal, drug and environmental factors in understanding risk, benefit and harm related to drug use • the use of non-binary models (e.g., Venn diagrams or quadrant models) in exploring drug-related issues
• recognize how official responses to drugs may have less to do with the drug than with other factors	• deconstructing messages, rules and policies to determine whose interests are being served • the interconnected nature of messages, interests, rules and power (in families, communities and cultures) • the range of outcomes that can result from various official responses
• develop social and communication skills in addressing discourse and behaviour related to drugs	• media awareness and critical thinking • the emotional and social appeal of drug use • self-examination and the exploration of ideas without immediately passing judgement
• develop personal and social strategies to manage the risks, benefits and harms related to drugs	• ways to assess personal risk and distinguish between beneficial and harmful use • decision-making skills that incorporate rational processing and emotional regulation • support and leadership skills within peer group, family and community

The Centre for Addictions Research of BC at the University of Victoria has been developing and collecting a variety of instructional examples and professional learning resources to help teachers apply this drug literacy curriculum. The centre will continue to develop instructional examples under their iMinds brand and is willing to consult with schools and districts about their particular needs. These instructional examples all contribute not only to building the drug literacy competencies outlined above but also support relevant big ideas, curricular competencies and core competencies (below) outlined in British Columbia's redesigned curriculum.



This resource was developed by the Centre for Addictions Research of BC with funding provided by the Government of Canada. Any views expressed herein are those of the authors and do not necessarily represent the views of the Government of Canada or the Centre for Addictions Research of BC.

Drug Education is Conversation

Dan Reist, MTh

The goal of education is to get children—no matter what their age—talking and sharing their thoughts and feelings. To be educated is not to know all the answers. It means having the competencies and confidence to engage on questions in pursuit of understanding. Indeed, education is more about questions than answers.

As teachers, parents or other adults, we have many opportunities to educate children. This includes honestly sharing our thoughts and feelings about psychoactive (mind-altering) drugs. But having honest, open conversations is more useful than telling students what to do or what to think.

Young people are more likely to explore, develop and share their ideas if we are open to the fallibility of our own views. Real discussion involves a curiosity about what the child thinks and feels. Offering a balanced and realistic perspective and demonstrating an openness to dialogue helps young people develop their own skills. In short, we would be wise to focus on inviting and supporting conversation.

Talk when it makes sense

Both school and life in general provide opportunities to have conversations about alcohol or other drugs. Even young children know alcohol is a part of our culture. They see people drinking around them. They are exposed to alcohol on TV and in advertising. In fact, drug use is part of the human experience. From caffeine to cannabis to cocaine, drugs have both helped and hurt people in nearly every society on earth. Teaching provides numerous entry points to a conversation about drugs. Literature, social studies, science and art all afford useful content. Or the subject emerges naturally while discussing life—music, celebrations or current events. Opportunities are everywhere.

Talking with children and youth about alcohol or other drugs helps them critically assess popular assumptions and develop personal views and skills. This provides them with the tools to navigate their world and take control of their lives.

This is not about the "drug talk" or "drugs class." Since drugs are encountered in so many aspects of life, the conversation is best infused into these other issues. This promotes a richer, more realistic discussion. It provides a way to engage more students with diverse interests. And it provides more opportunities to explore issues and build competencies.

Engage in dialogue

Real dialogue includes students in generating knowledge. The teacher sets an atmosphere that encourages input. She or he participates rather than controls, probes rather than tells. The teacher seeks to create a learning relationship with students and encourages them to build such relationships with others.

To engage in dialogue, we often need to set aside simplistic binary constructs such as good vs. bad. Instead, we explore together how the "good" and "bad" might inter-relate with one another. This more nuanced dialogue opens up new possibilities. The focus moves from debating who is right to exploring complex relationships. The result may be greater mutual understanding. Dialogue offers a way to address complex social issues like substance use where binaries have been unhelpful.

Dialogue allows us to break free of the usual social marketing approach to health education. This traditional approach seeks to "sell" students on a specific behaviour or belief. By contrast, dialogue helps students build the skills to explore and seek to understand and manage the human relationship with drugs.

University of Victoria | Centre for Addictions Research of BC

Promising Practice Series – 1

Things to talk about

Too often we think that simply talking about the negative effects of drugs will discourage young people from using them. The evidence suggests this may not be true. When we talk with children and youth about alcohol or other drugs, it makes sense to explore the reasons people use drugs, ways to manage the risks involved and alternatives to drug use. In other words, to help them understand the phenomenon.

Reasons

People have been using a wide variety of drugs for thousands of years. They are used to celebrate successes and help deal with grief and pain. They mark rites of passage and are used in pursuit of spiritual insight. Indeed, drug use is deeply embedded in our cultural fabric.

The reasons we use alcohol or other drugs influence our pattern of use and the risk of harmful results. People who use out of curiosity tend to use only once in a while. Ongoing motivations, such as relieving a chronic sleep or mental health problem, often lead to more prolonged and intense use. A desire to fit in, have fun or alleviate temporary stress may result in risky behaviour with high potential for acute harm.

Exploring the reasons together leads to useful discoveries. Through such conversations, we can better assess the situation. Furthermore, the student gains insight into their own behaviour or the behaviour of their peers.

Risks

All alcohol or other drug use carries some risk of harm. Sometimes the risk is very low and the benefits may outweigh the risks (e.g., a little may help a lot in an awkward social situation). Other times, the risk may be moderate, high or clearly harmful (e.g., drinking before driving or doing other things that put people's lives on the line). The level of risk is influenced by the amount used, frequency of use, age of the individual, the context in which use takes place, the reasons for use and personal factors including physical and mental health.

Substance use at an early age can affect the physical and mental development of young people. So the safest option for young people is to delay use until at least their late teens. Engaging young people in conversation about these issues allows them to explore reasons for not using.

If young people do use substances, they should at least know basic things about managing risk. This involves much more than knowing the "facts." Helping them *think through* the benefits, risks and mitigating factors is more important. Reflecting on the wisdom of the ages—not too much, not too often, only in the right context—is not a bad place to start.

Safer alternatives

Different cultures (families, social groups, communities or societies) promote different ways of dealing with life issues. This includes different attitudes towards various substances. Exploring these cultural differences opens up new perspectives. It suggests alternatives ways of seeing and acting. While we are all influenced by our cultural contexts, we need not be determined by them.

Dialogue provides a safe means to explore different ways of looking at the world and different ways of responding to life challenges. This allows young people to expand the ways in which they can meet their own needs. As we engage young people in this dialogue, they become more able to make healthy choices, to take control of their own health and to support their peers. They become educated.

Think before reacting

Schools are often politically charged environments. This can make it difficult to address topics like drug use in school. When we discover students have been using alcohol or other drugs, we can easily become reactive and punitive. But again, the evidence suggests such reactions are not helpful. They benefit neither the students involved nor their peers.

The most helpful response remains calm and open conversation. The goal is reaching an understanding with the students in which we gain insight into their behaviour and in which they gain insight into the social reality of their school and community. A thoughtful conversation is likely not possible while a teen is intoxicated or high. So address immediate safety needs and wait until later to have a talk. But our immediate actions should seek to preserve, rather than break, the students' social connections to their peers and the school community.

Wise sayings in many cultures point to the biological reality of "two ears, one mouth" to suggest we should listen more than we talk. Ultimately, getting the students to talk and discuss their views is the goal. As they talk, they explore their own ideas about what changes they might make. This is more powerful than telling them what changes we expect.

Conclusion

Good drug education is good education. It is not the teacher's job to impart official knowledge. Educators discipline minds. Students with disciplined minds make discoveries.

Conversation is a powerful tool in the teacher's toolbox. In conversation, students are challenged to reflect on their assumptions. They develop their ideas and consider other alternatives. In the end, we cannot control their decisions. We can, however, help them examine questions and develop useful ways of reflecting on potential answers.

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iMinds | A health literacy resource for K-12 schools

iMinds is a health education resource that seeks to maximize young people's drug literacy—the knowledge and skills they need to survive and thrive in a world where caffeine, tobacco, alcohol and other drug use is common. Building health literacy (including drug literacy) is one part of a comprehensive school health approach to addressing substance use (along with other behavioural health matters relevant to youth).

Developing drug literacy

Drug literacy is built by engaging students in honest, thoughtful discussions and projects that involve issues relevant to their daily lives. The goal is to encourage students to both express and think critically about drug-related beliefs, attitudes and behaviours.

"Really enjoyed the philosophy of iMinds and having students discuss "their" opinions" ~grade 6 teacher

Awareness, actions, decisions and behaviours are influenced by multiple factors including personal factors requiring self-awareness and self-management skills, relationships requiring social awareness and skills, and the physical and cultural environments requiring life knowledge and navigational skills. Therefore, students need to learn to …

- assess the complex ways in which drugs impact the health and wellbeing of individuals, communities and societies
- explore and appreciate diversity related to the reasons people use drugs, the impact of drug use and the social attitudes toward various drugs
- recognize binary constructs (e.g., good vs bad) and assess their limitation in addressing complex social issues like drug use
- recognize how official responses to drugs may have less to do with the drug than with other factors
- develop social and communication skills in addressing discourse and behaviour related to drugs
- develop personal and social strategies to manage the risks and harms related to drugs

"I've changed the way I teach and am using a more critical thinking approach" ~grade 7 teacher

What's in it for students?

Students examine the factors that influence the way they think, feel and behave. They learn about and discuss ways to address issues related to health and drug use that may arise for them, their families or their communities.

Drawing on social ecological theory, *iMinds* helps students develop awareness of themselves, their relationships and their environments and helps them build skills in all these dimensions. By addressing all three areas, students develop healthy connectedness—a sense of both autonomy and social belonging.

iMinds aims to give young people an opportunity to

- understand the long relationship humans have had with tobacco, alcohol, cannabis and other substances
- analyze personal, social and environmental influences related to drug use and other lifestyle choices
- develop strategies for attaining and maintaining physical, emotional and social health during childhood, adolescence and young adulthood

What teachers like about iMinds

iMinds does NOT require teachers to be "experts" on drugs or mental health. Instead, teachers serve as facilitators who explore ideas and issues along with their students. *iMinds* is based on a constructivist approach to teaching and learning. This involves the belief that learning occurs when students are actively involved in the process of carving out their own meaning of things they both experience and come to "know" from various sources.

iMinds is consistent with the new BC curriculum. Rather than passively receiving information, learners are motivated to think critically and become actively involved in the pursuit of knowledge. Together, the class identifies their current knowledge, explores other ideas and opinions, and acquires and demonstrates new knowledge related to drugs and health.

iMinds is not a program that teachers are expected to implement in a rigid fashion. Rather, it is a "way of thinking" about drug education and a collection of materials and ideas that teachers are encouraged to adopt and adapt as needed in their classroom and community contexts.

iMinds is relatively easy to implement in that it does not require a lot of preparation or any special equipment or materials.

What is available?

Initially, *iMinds* consisted of a set of multi-lesson modules for Grades 4-10. These are currently being supplemented by a wide range of learning ideas that can be easily incorporated into various curricular areas such as Social Studies, English Language Arts, Science and other subjects and settings. Resources are available in both English and French.

Access resources at www.iMinds.ca

iMinds | A constructivist approach to drug literacy

iMinds is based on constructivist educational theory. A constructivist approach is ideal for teaching drug literacy because it avoids setting the teacher up as the "drug expert." Teachers need not worry about being asked questions for which they do not have answers. The role of the teacher is not to provide answers—it is to create a context of inquiry.

The value of a constructivist approach

In constructivist learning all questions and comments can be heard, discussed, explored and weighed against evidence. Even students who go for shock value will soon learn that their ideas are simply that—ideas. By validating all students' inquiries and providing them with sources of information, facilitators encourage young people to become active thinking beings.

Tips for constructivist teaching

- **Stay neutral** and acknowledge all contributions in an unbiased but questioning manner. By showing respect to all students regardless of their opinions, you encourage them to do the same.
- **Insist on a non-hostile environment** where students respond to ideas and not the individuals presenting those ideas. Make it clear from the start that everyone must be open to listening to, and considering, views that may be different from their own.
- **Encourage all students to take part** in discussions, but avoid forcing anyone to contribute if clearly reluctant. Ensure students know their feelings and opinions are important and will be respected.
- **Keep discussions moving in a positive direction** by questioning or posing hypothetical situations that encourage deeper thinking about the topic.
- **Understand that consensus is not necessary** on issues, and that a lack of consensus is in fact a better reflection of "real life."
- **Get comfortable with silence** as sometimes discussions require reflection.

iMinds is part of the larger *Helping Schools* initiative within the Centre for Addictions Research of BC at the University of Victoria. Funding to support this initiative and to develop *iMinds* resources has been provided by the BC Ministry of Health, BC Partners for Mental Health and Addictions Information and Health Canada. All views expressed within the materials are solely those of the authors.

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The 5-i model

iMinds materials are developed using a 5-i model that reflects the various phases of constructivist learning. Each module and lesson idea has been developed with these different aspects of learning in mind. Teachers are encouraged to pay particular attention to these as they adapt and construct lessons based on *iMinds* materials.

identify

Students come to a learning situation with prior knowledge. The "identify" activities provide students and teachers with a means of assessing what they already know. The activities serve to engage students and encourage them to share their current ideas.

"I cannot teach anybody anything. I can only make them think."
~Socrates

investigate

Learning requires students to observe, analyze and evaluate as they interact with materials and ideas introduced through the "investigate" activities. The new evidence may be provided through the ideas of their peers as well as by other sources.

"It is the mark of an educated mind to be able to entertain a thought without accepting it."
~Aristotle

interpret

Students are encouraged not only to reach conclusions but also to assess the strength of evidence for those conclusions within a range of possible interpretations. The "interpret" activities encourage students to weigh evidence and assign meaning.

imagine

Students who know how to understand evidence and manage a range of possible interpretations are in a better position to use knowledge creatively. The "imagine" activities encourage students to consider how knowledge might apply to new possibilities.

integrate

Knowledge involves the ability to incorporate new ideas into what is already known, and to use this new knowledge in further explorations. The "integrate" activities allow both students and teachers to make a summary assessment of what students know and can do.

Quick Guide
to Drug Use

What are drugs?

Drugs are chemicals that change the way our bodies function. Psychoactive substances are drugs that affect our central nervous system (especially the brain) and make us see, think, feel and behave differently than we usually do. Some of the most commonly used drugs are caffeine (in cola, coffee, tea and chocolate), nicotine (in cigarettes, cigars and chewing tobacco), ethanol (in alcohol), and THC (in marijuana and other cannabis products).

Why do people use drugs?

People use drugs to get some benefit. For example, many people drink coffee to wake up and feel alert. And many people use alcohol to relax and unwind. Other drugs are used to take away pain or to address other problems. Some drugs are used to have a good time or to induce a spiritual experience.

How can using a drug be good and bad?

Many drugs, like certain medications, have greatly benefited human beings. In fact, most drugs are useful in some way. But all drug use also carries some risk. Even prescription medication from a doctor can cause harm, especially if not taken properly. It helps to think of drug use on a spectrum:

How much risk is involved in using a drug—and how much harm it may cause—depends on many factors.

1. **More drug equals more risk.** Increased risk is associated with a greater amount and increased frequency of drug use, and with a higher concentration of the drug.
2. **Younger age equals more risk.** The human brain begins to develop in the womb but is not fully formed until well into adulthood. Drugs influence not only our immediate experience but also the way our brains develop. Drugs have a greater impact on young brains than they do on older brains.
3. **Places, times and activities influence risk.** Drinking a glass of wine at a family celebration and then playing chess with grandpa is less likely to result in harm than sneaking alcohol with a group of classmates and then riding bikes or skateboarding.
4. **The reasons are important.** When a person uses a drug because they are curious, they are likely to use it only occasionally or for a short time. But when a person uses a drug to deal with long-term problems, they may use the drug too much or too often. When a person uses a drug in order to fit in with a particular group, they may not listen to their inner self and therefore may make poor choices.

Making good decisions about substance use involves always looking at both the benefits and the risks, thinking about the reasons the drug is being used, and ensuring the context is safe for use. Generally, it is safest not to use any drug unless one can be sure the benefits clearly outweigh the risks, and that the context and reasons for use do not increase the potential for harm.

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Appendix E

Language Matters: Reduce Stigma, Combat Overdose

Change the Conversation Regarding Overdose

March 09, 2017

Vancouver – The BC Centre for Disease Control (BCCDC) encourages the use of respectful, non-stigmatizing language when describing substance use disorders, addiction and people who use drugs.

"Negative, stigmatizing language, whether it is used in a healthcare setting or in the news media, discredits people who use drugs and can result in discrimination," said Dr. Jane Buxton, harm reduction lead at the BCCDC. "Stigmatization contributes to isolation and means people will be less likely to access services. This has a direct, detrimental impact on the health of people who use drugs."

In a report now available on TowardTheHeart.com, Dr. Jane Buxton and researcher Hiep Tu describe the stigmatizing language sometimes used in public and professional discourse, and the impact it can have on people who use drugs. Drawing on previous research into language used to describe addiction*, Buxton and the BCCDC encourage stakeholders to help change the conversation regarding overdose.

1 ***People-first language***. This means referring to a person before describing his or her behaviour or condition. This is important because it acknowledges that a person's condition, illness or behaviour is not that person's defining characteristic. "*Person with a cocaine-use disorder*" instead of "*cocaine user*" or "*addict*."

2 ***Use language that reflects the medical nature of substance use disorders***. There are a multitude of factors contributing to drug addiction, ranging from personal factors to social, environmental and political ones. Avoid terms that reinforce a belief that addiction is a failure of morals or personality, rather than a medical issue. "*Addictive disease*" and "*substance use disorder*" instead of "*abuser*" or "*junkie*."

3 ***Use language that promotes recovery***. This means healthcare professionals should use language that conveys optimism and supports recovery, and respects the person's autonomy. "*Opted not to*" and "*not in agreement with the treatment plan*" instead of "*unmotivated*" or "*non-compliant*."

4 ***Avoid slang and idioms***. Slang terms and idioms have negative connotations and a significant level of stigma attached to them. While slang and idioms are rarely used in professional literature, they are also important to avoid when speaking to other colleagues or healthcare professionals. "*Positive*" or "*negative*" when referring to drug tests, instead of "*dirty*" or "*clean.*"

**Adapted from Broyles L, Binswanger I, Jenkins J, Finnell D, Faseru B, Cavaiola A et al. Confronting Inadvertent Stigma and Pejorative Language in Addiction Scholarship: A Recognition and Response. Substance Abuse. 2014;35(3):217-221.*

Summary list of protective factors

Throughout this report a number of protective factors in the lives of BC students have been identified. This chapter provides a list of those protective factors along with an example for each from the report.

PROTECTIVE FACTOR	EXAMPLE
Stable home	Among students currently living in a foster home or a group home, those who had not moved at all in the past year were more likely than those who had moved to report good or excellent mental health (84% vs. 67%) and good or excellent health overall (86% vs. 71%).
Nine or more hours of sleep	Students in every grade who slept nine or more hours the night before completing the survey were more likely than students who got less sleep to report that their mental health was good or excellent (91% vs. 78%). Further, rates of good or excellent mental health increased with each hour of sleep that students got, with consistent findings for students in every grade.
Good nutrition	Youth who reported eating fruit and vegetables three or more times on the day before taking the survey were less likely than those who ate these foods less often to report extreme stress, and more likely to report positive mental health.
Sports and exercise	Students who played organized or informal sports were more likely than their less active peers to rate their mental health as good or excellent; to report feeling happy, calm and at peace; and to have slept nine or more hours the night before taking the survey.
Feeling safe at home, in school, and the community or neighbourhood	Youth who always felt safe in their neighbourhood at night were nearly twice as likely to have felt calm and at peace most or all of the time in the past month (65% vs. 34% of those who never felt safe).

PROTECTIVE FACTOR	EXAMPLE
Feeling connected to school	Students who felt highly connected to school were more likely to expect to continue their education beyond high school compared to those who felt less connected.
Feeling engaged in activities	Among youth who had experienced bullying, 13% of those who felt that their ideas were listened to and acted upon always felt safe in their school and community, compared to 6% of bullied youth who did not feel engaged in this way.
Feeling like family pays attention to them	Youth who felt that their family paid attention to them were less likely to have ever driven after drinking alcohol or using marijuana, less likely to have been a passenger in a vehicle with someone who had been using substances, and more likely to always wear a seat belt.
Parental monitoring	If students felt that their parent(s) or guardian(s) were monitoring what they were doing in their free time, they were less likely to have used their cellphone after they were expected to be asleep, and were more likely to have slept for nine or more hours the night before taking the survey.
Supportive adult in family	Students who had an adult in their family who they could talk to if they had a serious problem were less likely to forego accessing mental health services when they needed them (6% vs. 25% of students who did not feel they could turn to an adult in their family).

PROTECTIVE FACTOR	EXAMPLE
Caring adult outside family	Students who felt that an adult at their school or elsewhere outside their family cared about them were more likely to report that there was something they were good at (76% vs. 53%), and to have only positive aspirations for the future (89% vs. 70%). They were also more likely to have felt happy most or all of the time in the past month (69% vs. 34%).
Helpful adults	If youth with a mental or emotional health condition found a teacher they approached for assistance to be helpful, they were less likely to attempt suicide (28%) compared to those who approached a teacher but did not find this experience helpful (48%).
Having close friends (excluding online friends)	Having close friends in the neighbourhood or at school was linked to better health. The more close friends a student had, the more likely they were to report good or excellent mental health, and the less likely they were to be bullied. For example, 62% of youth without any close friends had been teased, excluded, or assaulted at school or on the way to or from school in the past year, compared to 48% of those with three or more friends.
Having friends with pro-social attitudes	Among youth in a romantic relationship, those who had friends who disapproved of beating someone up were half as likely to be the victim of relationship violence as those with friends who condoned this behaviour.
Community connectedness	Students who currently felt connected to their community were more likely to also see themselves engaged in their community in five years (17% vs. 6% who did not feel connected).
Cultural engagement	Students who participated in weekly cultural activities were more likely to feel that the activities they were involved in were meaningful (76% vs. 68% who participated less often) and that their ideas were listened to and acted upon (50% vs. 43%).

Appendix G

HOW DOES THERAPEUTIC RECREATION APPLY IN THE TREATMENT OF ADDICTIONS?

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Introduction

"Alcohol/drug addiction is a leisure disease and a disease of leisure! People pay for the feeling because they don't know how to get it free. That is, they don't know how to play in a manner that produces the desired feeling." (Faulkner, 1991, p.7). Addicts spend each day thinking about when, where and what they will use to achieve their next "high". Substance abuse and other addictive behaviors penetrate every facet of their lives and eventually their leisure time is totally consumed by addictive behavior. So what happens when they stop using chemicals and have free time on their hands? This article will help answer this question and examine the relationship between addiction and leisure, emphasize the importance of leisure in a healthy recovery, and make recommendations for treatment.

The Addiction - Leisure Relationship

There is little written work about the connection between therapeutic recreation and recovery from an addiction. Therefore, it may benefit the reader to gain a basic understanding of the meaning of addiction. There are many different definitions of addiction but for the purpose of this article it is defined as "...a physical and/or psychological dependence on a chemical agent or behavioral process. This disorder is characterized by the inability to resist using a substance and increasing one's use which eventually leads to compulsive use in terms of dosage and/or frequency." (Csiernik, 1993). This definition acknowledges that addiction is not restricted to chemicals such as alcohol or drugs but that it is also possible to have what is known as a process addiction. Schaef (1987) describes a process addiction as an addiction to relationships or to certain patterns of behavior such as gambling or sex. These people are "hooked" on a process rather than a chemical substance. It is important to recognize that this behavior is not simply compulsive in nature, but that it is accompanied by an adrenaline "rush" as well as other physiological changes. The experience produces a "natural high" that the addict will seek out in future experiences with the same activity.

When clients enter treatment, they abstain from all chemical substances and/or addictive behaviors and begin their journey in recovery. "Recovery is viewed as a long-term process of abstinence and change in physical, psychological, family, social, and/or spiritual areas" (Daley, 1989, p. 106). It requires that a person shift their focus from alcohol or drugs to other healthier areas of interest, learn healthy coping mechanisms, and emphasize increased valuing of self, others and life concerns (Brown, 1985). These are all new skills and behaviors for the recovering addict to learn, practice and incorporate into a balanced lifestyle. It can, therefore, be said that abstinence is only a small part of recovery compared to changes in lifestyle. This is where therapeutic recreation interventions play a key role to aid in the development of new skills so that healthy changes can be implemented successfully into a recovery oriented lifestyle.

It is widely accepted that most people take their first drink or drug during their leisure time. Society has created a link between substance use and leisure time in the sense that social drinking or experimentation with drugs is socially appropriate behavior and often an expectation in various settings. Addiction, as a result, has been described as a leisure disease and dysfunctional leisure is a symptom of addiction (Faulkner, 1991). Faulkner (1991) states that once the addiction takes hold, people often abandon leisure pursuits that do not permit substance use because they would rather stay home and satisfy their craving. This is how dysfunctional leisure becomes a symptom of addiction.

The sacrifice of healthy leisure for addictive behavior illustrates the reciprocal relationship between addiction and leisure. As the addiction increases in severity, the amount of healthy leisure decreases. This process of deterioration is described by Kinney and Leaton (1991) as they outline four stages in the development of alcoholism as it relates to leisure. This process can be applied to the development of addiction in general. The first stage is Social Use in which most people take their first drink or drug as a part of their leisure activity. As a result of this use they experience a positive mood change which enhances their leisure experience. The second stage is called Goal-Oriented Social Use. At this stage the unhealthy behavior is propelled by the individual's desire to achieve the goal of euphoria that was reached once before. Addictive behavior impacts upon the individual's leisure time without directly effecting work or family life. The third stage is called Harmful Dependence. This is when dependency becomes an issue and the things that were once enjoyed as leisure activities no longer matter. The individual recognizes that their using has negative consequences but decides that the positive effects outweigh the emotional, physical and social cost. In addition, activities that do not allow the use of substances are abandoned as the addict begins to lose sight of what is important. The final stage is Addiction. At this point, an individual uses to feel normal and avoid emotional pain and physical withdrawal. There is no more experience of euphoria and chemicals are used solely to cope with the issues of the past and problems of the present. There may be no healthy activities at this point because using has become the main focus. Therefore, using is no longer the choice, but the need. When the addiction takes hold, there is an overall decrease in all areas related to quality of life.

Leisure In Recovery

Two of the main goals of recovery are rebuilding relationships and learning how to enjoy life again (Mooney, Eisenberg & Eisenberg, 1992). Leisure is an ideal context for the redevelopment of family bonds and relationships (Hood, 1995) while having fun at the same time. Many people in early recovery find it difficult to imagine having fun without using drugs or alcohol. Yet most people, for the first time in many years, experience tear-producing, hysterical laughter during leisure time with their friends in treatment as they begin to enjoy living sober.

Austin and Crawford (1991) state that therapeutic recreation plays an important role in addiction treatment because of the emphasis on treating the whole person. It is the therapist's job to help recovering clients develop functional leisure activities and behaviors that are in tune and in balance with other lifestyle needs, and discover the good things in life that were missing in an intoxicated state (Faulkner, 1991). Restoring this balance requires a person to assess the routine duties and obligations of life ("shoulds") and the self-indulgent, enjoyable activities ("wants") and make sure that the former does not outweigh the latter (George, 1989). When there are more obligations than enjoyable activities, feelings of deprivation tend to surface and cause an overwhelming need for self-satisfaction which can result in addictive behavior as a "quick fix". Therefore, participation in regularly scheduled constructive indulgences can maintain wellness and remove the imbalance that threatens sobriety (George, 1989).

It is important for recovering persons to adopt leisure as a way of living in order to make the necessary lifestyle changes and create a healthy balance. Godbey (1985) defines leisure as "living in relative freedom from the external compulsive forces of one's culture and physical environment so as to be able to act from internally compelling love in ways which are personally pleasing, intuitively worthwhile, and provide a basis for faith" (p. 9). Essentially, this means living one's life to its fullest from a leisure perspective. In recovery, this requires moving from a life described as hectic, restless, depressed, anxious, withdrawn, and bored to a life that is relaxed, easygoing, playful, at peace, and having the ability to get lost in the moment (Rifkin, 1994). To this end, leisure involves a sense of intrinsic satisfaction (Kelly, 1982) that cannot be bought, ingested or forced on a person.

Recreation and leisure in recovery involves taking risks by trying new activities for the first time or engaging in past leisure interests for the first time in many years. It is often the case that clients refrain from trying anything new because they are afraid of failing or appearing foolish. A little encouragement goes a long way when clients are unsure of themselves and when they succeed, they experience a sense of pride, self-confidence and increased self-esteem.

Participation in recreation and leisure in early recovery aids in the development of many skills that are used on a daily basis. Because isolation is such a common behavior in people who are addicted, social skills development is emphasized and these skills are practiced and improved through interactions with other recovering individuals. The meetings of Alcoholics Anonymous encourage people to "come early and stay late" in order to connect with other people in recovery and create a sense of belonging that has been absent for so long.

Other skills include decision-making, problem solving, relaxation training, assertiveness training, stress management and organizational skills. Learning and practicing these new, healthy coping skills helps clients deal positively with emotions such as anxiety, disappointment, confusion, and frustration which often occur during leisure activities.

Support for the inclusion of a fitness program in the treatment of addiction can be found in the literature. It is often the case that clients led a very sedentary lifestyle before entering treatment which resulted in a deteriorated state of physical health. These people require time to rebuild their physical strength and achieve a basic level of fitness. Sinyor, Brown, Rostant and Seraganian (1982), in a study of the role of recreation in an addiction treatment facility, found that those who took part in a fitness program during treatment had greater abstinence rates and experienced healthy changes in their fitness levels. Although not being able to provide a definitive reason for the results, Sinyor et al. (1982) put forward a number of possible explanations. It was suggested that an improvement in fitness levels allows a person to cope better with stress and can help in alleviating depression and anxiety. They said that enhanced fitness levels may allow people to deal more effectively with emotional upset without resorting to substance use. Finally, the authors speculated that the individual may become more receptive to change, that the program may assist in the reorganization of leisure time and that new activity patterns may make the transition back to the work environment less traumatic.

A combination of a physical fitness program, healthy recreation activities and fulfilling leisure time will aid in the development of a healthy recovery by addressing the individual's physical, social, emotional and spiritual needs - by addressing the whole person.

Treatment Recommendations

Addiction treatment programs are very intense and often overwhelming for the client who is trying to gain insight into themselves and their behaviors while experiencing withdrawal symptoms. This process often consumes clients physically, emotionally and cognitively, leaving them with an overwhelming amount of information to digest and practice. The

recreation therapist's role is to create a balance in their program to increase the overall effectiveness of treatment (Hood, 1995).

There are a number of issues regarding a client's leisure lifestyle that must be addressed during treatment. One of the first things the therapist needs to address is the client's perceptions of leisure. What are the core values and beliefs regarding leisure? Was leisure valued by the family of origin? Most clients will have little motivation towards healthy leisure because they had no use for it when they were active in their addiction. In their eyes, leisure activities are of little value because they don't provide the immediate gratification that was met through addictive behavior. It is the therapist's duty to challenge these perceptions and help clients in their journey to discover meaningful leisure.

"Finding leisure" is an experiential process that involves experimenting with a number of different recreational activities to determine which ones meet a client's needs. The therapist must introduce clients to healthy leisure choices in a structured, non-threatening environment. Clients should be encouraged to take risks and try something they have never done before. The result is almost always positive. After all, success, failure, likes and dislikes are all a part of personal growth and discovery.

An activity inventory is a useful tool to compare current levels of participation (upon entering treatment) to past levels of participation (before addiction). Normally there is a significant decline in leisure interest and participation when the addiction increases in severity. The activity inventory can reveal important treatment issues regarding balance and variety of activities, and the number of interests that were abandoned during active addiction.

In order to facilitate the client's understanding of why healthy leisure decreased during their addiction, it is beneficial for them to look at their motivation for engaging in addictive behavior. In my experience, when clients are asked why they engaged in this behavior, the most common responses are:

1. To relieve tension and pain (emotional & physical).
2. To escape from reality.
3. To be more sociable and outgoing.
4. To increase sense of power and control - feel stronger and more confident.
5. To increase ability to cope with the problems and stresses of everyday life.
6. To create a positive mood - get happy, have fun.
7. To gain a sense of belonging. 8. To relieve boredom.

If you look closely at this list you will see that these are all needs that can be met and benefits that can be derived from healthy leisure. This process helps clients realize that the benefits of using are the same benefits of leisure so that they can begin to see how healthy activities can help them cope with these issues. It is easier for addicts to give up the rewards from their addiction when they know they can get gratification from healthy activities.

The next step is to give clients the opportunity to experience these benefits first hand. The addict must now replace using with a balance of healthy activities which may involve learning a whole new set of skills and behaviors. Clients often surprise themselves by succeeding at something they did not think they could do. When this happens they experience an increase in pride, self-esteem, and self-worth while doing an activity that creates a positive mood, relieves boredom and provides a sense of belonging to a group.

Experimenting with different leisure activities in treatment provides an opportunity for clients to feel at ease with others and feel comfortable with themselves. For an addict who was never allowed to laugh and be silly as a child, it is important to emphasize that this kind of behavior is appropriate during leisure time. In fact it is necessary in order to get in touch with the inner child.

The therapist must be aware that solitary activities are not recommended for addicts in treatment. Addicts spent a great deal of time in isolation during addiction and for many clients, isolation is an unhealthy way of escaping from the problems of life. There are more benefits to group activities which provide clients with an opportunity to connect with others. For example, a scheduled fitness walk that is incorporated into treatment on a daily basis as a group activity acts as a deterrent for isolation.

In addition to recreation activities, clients must also be introduced to coping skills like stress management and relaxation training. These are skills that can be used in conjunction with leisure or on their own. Addicts need to be taught how to achieve a state of relaxation and deal with stress appropriately because these needs were previously met in unhealthy ways with a "quick fix".

It is also important to explore barriers to healthy leisure. Two of the most common barriers that addicts identify include feeling guilty about doing something for themselves and an activity's affiliation with using. The first barrier is very common because addicts in early recovery often experience extreme guilt over the time they lost with their loved ones when they were actively using. The therapist must help clients understand that they cannot take care of anyone else

until they take care of themselves. Positive self-talk and healthy self-rewards can assist in the growth process toward feeling worthy of time to themselves.

The second barrier must be addressed for "safety" reasons. If an activity, such as golf, had a strong affiliation with drinking, then it may be "unsafe" to return to that activity in early recovery. Safety refers to the risk of exposure to old behaviors. The recovering addict needs to take precautions when returning to activities in which addictive behaviors took place by changing the people and the place that surround the activity. Different groups within Alcoholics Anonymous have organized sober events such as dances, hockey teams, camp-outs and even cruises. Making the choice to socialize and engage in activities with sober people will create a safe environment that promotes recovery.

Prior to discharge from treatment, clients should be planning for leisure and setting goals that they can work towards after being discharged. Planning for leisure is an important step because it helps the clients follow through with their intentions. Kelly (1982) describes leisure as free time - time outside the obligations of life such as work and maintenance activities. For the addict this was always a time to use. Therefore, in recovery the addict needs to structure their free time and use that time to engage in healthy activities. In addition, clients need to look at the time of day when they routinely engaged in addictive behavior and implement these healthy activities as a replacement during that time. Setting specific goals and determining the steps that must be taken to reach those goals can help clients move from the contemplation stage to the action stage and create a motivation to succeed.

Most importantly, the therapist must act as a role model for healthy behavior. Therapists must practice what they preach and live a leisure lifestyle using healthy coping skills or else they will lose credibility in the client's eyes.

Conclusion

There is clearly a difference between living and existing, and leisure is the part of recovery that allows a person to live. In treatment, therapeutic recreation is an essential service that models lifestyle change, balance and healthy coping skills. For the addict, it answers the question "What am I going to do for fun now that I'm not using?" and it is the piece of the recovery puzzle that makes it complete. The client's overall goal should be sobriety (beyond abstinence) and in order to achieve this goal, the therapist must assist the client in reshaping lifestyles and values and eliminating the dependence on addiction (Kunstler, 1991). In other words, the therapist must help the client find healthy means to satisfy the needs previously met through using.

Leisure is an ideal context for trying new identities in sobriety and to determine the results of these new identities on self and others; therefore, re-creating oneself (Hood, 1995). Finally, leisure may be the ideal context for self-discovery in which clients will realize that it is possible to have fun without the use of chemicals.

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Appendix H

40 Developmental Assets® for Adolescents (ages 12-18)

Search Institute® has identified the following building blocks of healthy development—known as **Developmental Assets®**—that help young people grow up healthy, caring, and responsible.

External Assets

Support

1. **Family support**—Family life provides high levels of love and support.
2. **Positive family communication**—Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parents.
3. **Other adult relationships**—Young person receives support from three or more nonparent adults.
4. **Caring neighborhood**—Young person experiences caring neighbors.
5. **Caring school climate**—School provides a caring, encouraging environment.
6. **Parent involvement in schooling**—Parent(s) are actively involved in helping young person succeed in school.

Empowerment

7. **Community values youth**—Young person perceives that adults in the community value youth.
8. **Youth as resources**—Young people are given useful roles in the community.
9. **Service to others**—Young person serves in the community one hour or more per week.
10. **Safety**—Young person feels safe at home, school, and in the neighborhood.

Boundaries & Expectations

11. **Family boundaries**—Family has clear rules and consequences and monitors the young person's whereabouts.
12. **School Boundaries**—School provides clear rules and consequences.
13. **Neighborhood boundaries**—Neighbors take responsibility for monitoring young people's behavior.
14. **Adult role models**—Parent(s) and other adults model positive, responsible behavior.
15. **Positive peer influence**—Young person's best friends model responsible behavior.
16. **High expectations**—Both parent(s) and teachers encourage the young person to do well.

Constructive Use of Time

17. **Creative activities**—Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.
18. **Youth programs**—Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community.
19. **Religious community**—Young person spends one or more hours per week in activities in a religious institution.
20. **Time at home**—Young person is out with friends "with nothing special to do" two or fewer nights per week.

Internal Assets

Commitment to Learning

21. **Achievement Motivation**—Young person is motivated to do well in school.
22. **School Engagement**—Young person is actively engaged in learning.
23. **Homework**—Young person reports doing at least one hour of homework every school day.
24. **Bonding to school**—Young person cares about her or his school.
25. **Reading for Pleasure**—Young person reads for pleasure three or more hours per week.

Positive Values

26. **Caring**—Young person places high value on helping other people.
27. **Equality and social justice**—Young person places high value on promoting equality and reducing hunger and poverty.
28. **Integrity**—Young person acts on convictions and stands up for her or his beliefs.
29. **Honesty**—Young person "tells the truth even when it is not easy."
30. **Responsibility**—Young person accepts and takes personal responsibility.
31. **Restraint**—Young person believes it is important not to be sexually active or to use alcohol or other drugs.

Social Competencies

32. **Planning and decision making**—Young person knows how to plan ahead and make choices.
33. **Interpersonal Competence**—Young person has empathy, sensitivity, and friendship skills.
34. **Cultural Competence**—Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
35. **Resistance skills**—Young person can resist negative peer pressure and dangerous situations.
36. **Peaceful conflict resolution**—Young person seeks to resolve conflict nonviolently.

Positive Identity

37. **Personal power**—Young person feels he or she has control over "things that happen to me."
38. **Self-esteem**—Young person reports having a high self-esteem.
39. **Sense of purpose**—Young person reports that "my life has a purpose."
40. **Positive view of personal future**—Young person is optimistic about her or his personal future.

Appendix I

CHAPTER 22

Trauma-Informed Practice: Working With Youth Who Have Suffered Adverse Childhood (or Adolescent) Experiences

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Related Video Content

22.0 Trauma-Informed Practice: Working With Youth Who Have Suffered Adverse Experiences

Why This Matters

Youth who have experienced trauma have learned to be reactive. In fact, their brain, stress hormones, and even the expression of their DNA have been altered by their adverse experiences. As a matter of survival, some youth may have needed to act reflexively before thinking, to take an offensive stance rather than leave themselves vulnerable. Others may have learned to dissociate themselves from the horrors they experienced—to zone out or disconnect from reality when they were powerless to change it.

We introduce a radical calmness in their chaotic realities. We acknowledge trauma. We name it to address it, we address it to resolve it, and we resolve it by empowering youth to define themselves outside of their past traumas.

Adverse childhood experiences can affect people in every racial and ethnic group, and occurs across all economic strata. Therefore, we must consistently practice in a trauma-informed manner that assumes the young person we serve has endured severe adversity. This assumption reminds us to ask the right questions, interact

with young people in a way that will not trigger their reactivity or cause them to dissociate, and structure our practices in a way that will not re-traumatize youth by reinforcing their sense of powerlessness or shame.

The Effects of Toxic Stress and Trauma on Development and Well-being

The immediate and long-term effects of stress and trauma are discussed in detail in Chapter 6. The following points represent a brief summary:

- *Positive stress* produces short-lived physiological responses that promote growth and change necessary for healthy development.
- *Tolerable stress* occurs as the result of more severe, longer-lasting difficulty. If it is time-limited and there are sufficient social supports, there can be recovery without long-term negative effects.
- *Toxic or traumatic stress* can change the brain's architecture with long-term physical, emotional, and psychological consequences. Research demonstrates that adverse childhood experiences (ACEs) affect health over the life span.
- In response to adversity, we prepare for fight or flight. When this is a response to real danger, is time-limited, and is effective, it is life-saving and adaptive. Problems arise when this reaction is evoked in the absence of any threat, when the threat is prolonged, or when nothing can be done to protect oneself from the threat.
- Under conditions of chronic stress, something goes wrong as the body attempts to cope with a chronic overload of physiological responses. The system can become dysregulated, resulting in dysfunctional and maladaptive brain activities. People who have been severely or repeatedly traumatized are in a state of chronic hyperarousal and may lose the capacity to modulate their level of arousal.
- Under normal conditions, the brain is constantly integrating every component of experience—behavior, emotions, sensations, and knowledge. Under extreme stress, the brain stops properly integrating experience, leading to *dissociation*. As an acutely adaptive state, dissociation prevents a vulnerable and frightened person from needing to process an unimaginable reality. In the longer term, the loss of integration creates significant problems.
- Putting all of this together, we might note the following in teens who have experienced trauma:
  - It may be harder to forge a trusting relationship, because the young person has not experienced adults as consistently safe.
  - Parents and teachers may describe the youth as easily upset, easily provoked, or highly reactive.
  - The youth may display what others consider inappropriate emotions and behavior.
  - The young person may be triggered by traumatic reminders, and emotional responses may be occurring during an altered state during which the youth experiences flashbacks.
  - The youth may be diagnosed as hyperactive, oppositional, or conduct disordered.
  - The teen may appear inattentive as he is focused on internal stimuli or hyperattentive to "danger signals" of which adults are not aware.
  - A common post-traumatic presentation is dissociation. This may be reported as "lying," which actually represents a confabulated reality produced to replace actual events difficult to recall, or "zoning out," which has proven adaptive during traumatic moments.

The Protective Force of Connection With Caring Adults

Substantial research demonstrates the protective nature of caring connections with adults. Children exposed to trauma or toxic stress who also have a nurturing parent are far less likely to suffer long-term consequences from ACEs.

A person's repertoire of responses to high levels of stress is often described as fight–flight–freeze. However, the data that prove how protective connection is in early childhood supports the work of Taylor et al[1] that suggests "tend and befriend" is also part of the stress response. The question, of course, is whether others will be there to care for children in need of attentive care.

Although there is not yet a parallel body of evidence that proves the powerful protective nature of connection against trauma during adolescence, it remains our most important tool. This chapter, at its core, is about how to connect with traumatized youth to offer them the needed support to move forward.

Behavioral and Emotional Manifestations of Trauma

Many kinds of symptoms become intertwined with development over the course of time, making the symptom picture complex and sometimes perplexing. There is no classic picture to which all traumatized youth adhere; however, certain behavioral constellations are common and may raise concern that a history of trauma drives the behavior. Bear in mind, however, pain and trauma can also result in resilience and a deep commitment to repair the world.

In some cases, the young person's life becomes organized around unintegrated fragments of experience. They remain stuck in time, unable to move ahead, haunted by an unspoken and unresolved past. The most significant and recurrent problems will arise in young people who have been exposed to high levels of toxic stress, traumatic stress, and allostatic load (the wear-and-tear on the body and brain resulting from forces such as poverty, bigotry, chronic hunger, and lowered socioeconomic status). If we summarize what actually shows up differently in every youth, what do we see?

They may have a fundamental mistrust of others, especially adults because adults have not proven trustworthy and have often betrayed their trust. They have developed a protective shell around their emotions; they are numb and want to stay that way. They are most likely to become aggressive toward themselves or others as a way of warding off disturbing feelings, memories, or traumatic reminders, but they cannot openly talk about any of this. Instead, they communicate largely nonverbally, through behavioral reactions. They are unable to remember the worst aspects of their experiences, have difficulty learning from new experiences, and tend to repeat relational patterns from the past. They often do not recognize danger until it is too late and are unlikely to make meaningful connections between their previous experiences and the problems they are having in the present. They are likely to have very uneasy relationships to authority. They seem unable to anticipate the consequences of their behavior. They feel helpless and hopeless about being able to solve their problems, even while denying they have any. They are likely to have a very confused, injudicious, and erratic sense of justice and fair play. Real and imagined loss of any sort is likely to be a trigger for negative emotional reactions.

In brief, (1) they have difficulty maintaining safety in interpersonal relationships largely due to disrupted attachment experiences and the erosion of trust that accompanies such experiences; (2) they have significant challenges in adequately managing distressful emotions in ways that are not self-destructive, including exercising the capacities for self-discipline, self-control, and willpower; (3) cognitive problems beset them, particularly when stress occurs and the development of essential higher-level brain functions has not

The Sanctuary Model: Healing = Integration

Over time and after working with many survivors of terrible life events, we recognized that their past experiences had produced symptoms of post-traumatic stress and the chronic hyperarousal that accompanies it, but often with no memory. The symptoms were the remnants of attempts to cope with overwhelming stress and had become firmly entrenched bad habits, severely compromising their capacity to create and sustain interpersonal trust. The challenges presented to us as helpers were significant and, without this new understanding, incomprehensible.

Understanding that most of the symptoms we were seeing were secondary to a failure to fully integrate past experiences, we began to see how we could meaningfully facilitate recovery. We had to teach safety skills so they could build their capacity for trust. They had to learn how to manage intense emotion in safe and secure ways and to learn to use reason and judgment even in the face of emotional arousal. We had to teach communication skills so they could clearly assert their needs, create safe boundaries, and exercise self-control and self-discipline. We had to help people mourn for what was lost, prepare for the losses associated with change, and imagine a future that would make all of this new learning and habit change worthwhile.

This then was what we came to understand as "trauma-informed" treatment. As we saw it unfolding, developing these cognitive-emotional-behavior skills set the stage for trauma-specific treatment approaches that had a cathartic effect and helped people integrate fragmented bits of experience into a cohesive whole that allowed the past to reside safely in the past rather than continuing to haunt the present. This was RECOVERY.

Experience in creating healing environments taught us that we had to have a very broad definition of what it means to be safe and secure. Our clients reacted to a multitude of toxins, some from their families, some from others, and some from dysfunctional systems that were supposed to help them. All of this represented a loss of social support, which is the only barrier any of us have against the cruelties of life.

In order to create safe environments for healing, we needed to concern ourselves not just with physical safety, but with psychological, social, and moral safety as well. That meant staff had to "walk the talk" if we were to be trusted. When we grasped the enormous power behind the reenactment dynamic (the powerful inclination to repeat the past that is so typical of human behavior), we realized interpersonal trust was vital. If our clients were to change, they would have to make significant decisions to go against their own "instincts" and listen to us instead. But, we recognized that we were not always trustworthy. Things had happened to us as well, and those injuries had shaped who we had become as helping professionals. If we wanted our clients to change, then we had to change as well.

In the context of the treatment/intervention setting, much is demanded of anyone associated with young people. We must model and support the development of (1) safety skills and significant improvements in the capacity for interpersonal trust; (2) emotional management skills, including self-control, self-discipline, and the exercise of willpower; (3) cognitive skills, including identifying triggers and problematic patterns while still being able to think in the presence of strong emotion; (4) communication skills that include rehearsals in what to say and how to say it; (5) participatory and leadership skills; (6) judgment skills, including socially acceptable and fair behavioral schemas; and (7) skills to manage grief and plan for the future.

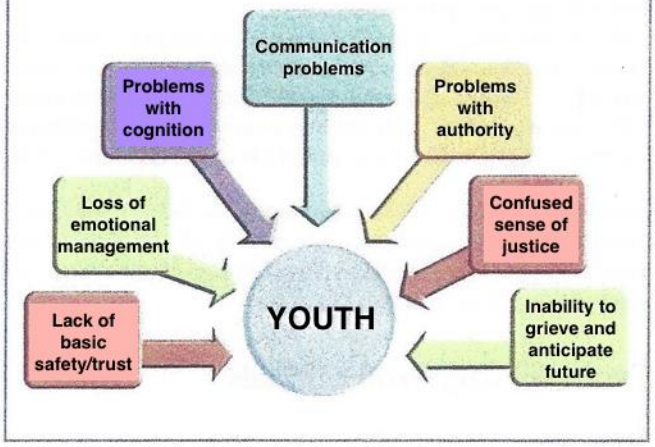
What characteristics best describe people able to do this complex, demanding work? They need to be secure, reasonably healthy adults who have good emotional management skills themselves. They must be emotionally intelligent and able to teach new skills and routines while serving as role models. There are constant demands on them for patience and for empathy so they must be able to endure intense emotional labor. To balance the demands of home and work, managers and supervisors, children and their families, they must be self-disciplined, self-controlled, and never abuse their own personal power.

That means that the place in which you serve youth, the practice context, must be a safe and healthy environment for everyone, including staff. Young people can sense immediately if an environment is hostile, even without any overt visible behavior. It must have a *commitment to open communication;* how else could it become a place that is (ultimately, when the youth is ready) safe enough to discuss the "undiscussables"?

The sanctuary model is described fully in Bloom SL, Farragher B. *Restoring Sanctuary: A New Operating System for Trauma-Informed Systems of Care*. New York, NY: Oxford University Press; 2013.

gone as smoothly as it should; (4) as a result, open and direct communication at home, at work, and at school pose significant challenges and they frequently communicate through behavior, not directly, openly, or in words; (5) they feel helpless and powerless in the face of a world they perceive has been unjust and cruel and, as a result, may be repeatedly bullied or become bullies themselves; (6) living under adverse conditions, these youth frequently do not develop a clear sense of social responsibility even into adulthood, and moral development may have been affected by disrupted attachment experiences and inadequate role models; (7) they are likely to have experienced significant loss while lacking the capacity to grieve secondary to emotional management problems, may repeat the experiences that are a part of their past, and often lack any hope that the future will be any better; and (8) their emotional and cognitive challenges interfere with the capacity to plan ahead and tolerate delayed gratification (Figure 22.1).

FIGURE 22.1
TRAUMA-ORGANIZED INDIVIDUAL



How Might Youth Be Described?

"It doesn't take anything to set this kid off!" This is a good description of chronic hyperarousal as a result of which the teen is easily provoked, highly reactive, and displays what others consider to be inappropriate emotions and behavior. Unrecognized by others, the youth may be triggered by traumatic reminders in the environment, and the emotional responses may be occurring during an altered state during which the teen is experiencing flashbacks.

"This kid cannot keep still and he won't pay attention." Some hyperactivity may actually be secondary to chronic hyperarousal and the physical agitation that accompanies it. Remember, under normal conditions, the stress response is preparing our minds and bodies to physically *react,* not to sit quietly and listen. The chemistry of a chronically hyperaroused young person is set to attend and respond to *danger,* not to geography or geometry. You may also hear something like, *"with this kid, things go in one ear and out the other."* Again, this may represent the cognitive problems associated with chronic hyperarousal since only things tagged with danger are cognitively attended to and retained.

"This kid is really going to hurt someone." Aggression can get people to distance themselves from you, an especially important response if someone is getting a little too close to you and to the memories you cannot process. But it is important to recognize

that aggression is a normal part of the human stress response—the *fight* part. The more frightened or startled we are, the more likely we are to respond aggressively and our body responds with aggression long before our brain has time to make a judgment about whether or not fighting is a good idea.

"This girl is a pathological liar—she lies all the time, even when it's obvious she'll get caught." No one is likely to come to you with the complaint that a youth is dissociative. You may hear accusations of lying, but the behavior may be confabulation. A person who has gaps in time where she does not remember what happened or who she was with will fill in the gaps with whatever seems like it might fit. Young people who do this are often very poor liars; their lies are frequently glaringly obvious and without underlying motivation.

"This kid is looking for trouble." Parents or teachers may complain about a teen who causes trouble wherever he goes and who takes unnecessary risks. Traumatized youth can become physiologically "addicted to trauma" and unwittingly hooked on the internal physical changes associated with the stress response.

"He's a loner." The difficulties that chronically traumatized youth have in trusting others can lead to severe deficits in age-appropriate social skills.

"Nothing bothers him. He has enough to handle just managing his pain." Many young people will internalize their pain and present with somatic symptoms (fatigue, dizziness, pain syndromes). They are not "faking"; their pain is real. They are unlikely to grasp the connection between the trauma and their pain, but may be guided toward understanding that their pain worsens with stress. Over time, therapy is an important part of the healing process.

"He's got oppositional defiant disorder/conduct disorder/bipolar disorder/attention-deficit disorder." Trauma generates volatility, moodiness, and reactivity. Always consider that a young person diagnosed with one of the psychiatric disorders that also manifests with unstable behavior or mood actually has a history of trauma.

Tips for Youth-Serving Professionals

Interview and Assessment

Youth-serving professionals are on the front lines in identifying and responding to young people who have already experienced adversity as well as those at risk. In light of this, accurate screening and assessment becomes essential. Because we may be unlikely to have the time or knowledge to do in-depth assessment, it is important to work with colleagues and have a referral network. Regardless of the depth of involvement your position allows, remember that every time a youth interacts with an adult there is an opportunity for a trustworthy interaction.

- Ask about the trauma history like you would any other part of the history—it doesn't mean you have to fix it. It does, however, mean you need a sound and reliable referral network so that you can make whatever effort you can to provide integrative body-mind-spirit care. You may say, *"At some point in their lives, many people have experienced extremely distressing events, such as the death of a loved one, physical or sexual abuse, or a bad accident. Have you ever had any experiences like that?"* You don't have to go into details but be matter of fact, direct, supportive, and encouraging. Use language that is concrete and specific to behaviors. Not, *"Were you ever sexually abused?"* but, *"Did anyone ever force you to have sex with them, including unwanted touching, against your will?"* Not, *"Are you being physically abused?"* but, *"Is anyone now hitting you repeatedly or physically harming you?" "Has anyone ever hit you repeatedly or physically harmed you?"*
- Make no assumptions about how the young person has been affected—ask him.

How Do We Work With Our Traumatized Youth?

Unconditional LOVE

1. Because our youth come from a place of mistrust/distrust toward adults, we stress relationship building as the foundation that holds the rest of our work and progress with each student. We reach out to youth through casual conversations, a game of ping-pong and, generally, through relating on a human level. The optimal atmosphere when working with trauma is one in which youth and staff are unafraid of having or discussing healthy human experiences. We affirm our roles as professionals while still making ourselves relatable and approachable.
2. We give them the opposite of what they are used to. They are used to abusive relationships and we give them a safe place of compassion and love, and one that is free of judgment.
3. We don't undermine their acuity/perceptiveness in picking up on triggers and responding to their perceived/real threats. If it's real to them, it is real and worthy of a space to be heard and processed.
4. We are honest and hold them to the standard of staying honest with themselves and us.
5. We empower them to break abusive patterns in their lives. We advocate wholeheartedly.
6. We are active listeners who play back their stories with an outsider's voice.
7. We are unafraid of showing them what is both right and wrong in how they deal with conflict. We hold them accountable when negative behaviors become comfortable coping mechanisms.
8. We cannot react back to their behaviors.
9. We stay mindful of the big picture and their point of reference when we see inappropriate behaviors.
10. We do not speak over them. If they are in an escalated state, we provide a safe space for them to take a time-out and pass the reactive state. We work to get them into a reflective and thoughtful state, thereafter using calm, respectful tones.
11. We introduce a radical calmness in their chaotic realities.
12. We let them be their own teachers by learning from their patterns in their lives or in their family and friends' histories. We let them be the authors of their own stories.
13. We acknowledge trauma. We name it to address it, we address it to resolve it, and we resolve it by empowering youth to define themselves outside of their past trauma(s).
14. We focus on what is right rather than what is wrong in them. We take a strength-based approach instead of a fix-it approach.
15. We encourage a high emotional base with youth to allow them to feel and express suppressed emotions or those others have invalidated.
16. We choose our words carefully; we use words that construct versus destruct. We don't generalize negative behaviors by making global judgments on youth (for example, "You are bad because you act like this."). Instead we work to have them replace negative self-image with a positive and confident self-esteem.
17. We allow and encourage the necessary meltdowns or breakdowns to reach the breakthroughs. We are prepared to see and handle high-intensity situations.
18. We are conscientious of our body language, tones, and word choice.
19. We reinforce that relationship-building, in and outside of the school, is foundational to their recovery.
20. Sometimes in order to focus on academics, we have to first address trauma.
21. Stay innovative and creative. We are inventive in how we approach nuanced situations without imposing an inflexible predetermined approach to youth.
22. We keep a dignified space/energy that is inviting but demanding of a high level of respect, both to self and others.

—Wisdom from resilience specialists at El Centro de Estudiantes

- If a teen discloses something that reveals her experience of past trauma, listen. Don't pressure her and don't falsely reassure her. You are a mandated reporter, so there is only so much you can promise. Never promise what you cannot deliver. Follow her lead—if she clams up, ask her if it would be easier to write it down.
- Sexual victimization of children is appallingly common, so know the signs, such as early substance abuse, chronic running away, self-harming behavior, eating disorders, abrupt personality changes, and sexual promiscuity. Alone, none of these prove sexual abuse occurred, but, combined with the history and with each other, they can be strong indicators.
- Adolescents are often embarrassed by their bodies and any kind of physical examination. Be on the lookout for young people who react strongly in 1 of 3 ways to physical examination. Strongly consider the possibility of past or present physical maltreatment or abuse if the youth is nonchalant or brazen in their disregard for what you are doing, is hypersensitive to or repelled by touch, or behaves in a sexually provocative manner.

Interpersonal Interactions

- Many who have experienced trauma have a harder time distinguishing between healthy and unhealthy relationships. Therefore, the issue of trust and betrayed trust will be a major ongoing issue. Relationships worthy of trust are the foundation of progress.
- Appropriate boundaries are key underpinnings of relationships. Because traumatized youth have so little experience with trust, breaking their trust or not following through on a perceived commitment can cause great harm.
- Think about the possibility of past adversity as an underlying problem when you are up against something you don't understand. If you cannot understand why someone does or doesn't do something that seems to be common sense, be curious and ask, *"What happened?"*
- Offer youth the absolute respect and unconditional love they may never have experienced.
- Do not speak over them. If they are in an escalated state, provide a safe space for them to take a time-out and pass the reactive state. Use calm tones and space to guide them out of their altered state
- Be an active listener; play back their stories with an outsider's voice. Be unafraid of showing them what is both right and wrong in how to deal with conflict. Hold them accountable when negative behaviors become comfortable coping mechanisms.
- Don't belittle their sensitivity. If it feels real to them, it is real and worthy of a space to be heard and processed.
- Allow psychiatric diagnoses to inform your approach, but not to define the teen. Remember, traumatized youth are often misdiagnosed.

Support and Treatment

- Psychoeducation can change a person's view of themselves, and that is often enough to increase adherence to other strategies. Handouts, books, movies, and Web sites are available and cover a wide range of relevant topics.
- Write everything down that you want them to retain. Assume that, under stress, people are not taking in all the information they need
- Encourage activities that are self-soothing—meditation, mindfulness, prayer, yoga, etc. If you can, offer opportunities for young people to learn to practice these skills individually or in groups.
- Encourage creative activities—writing, art, music, dance, theater—anything that offers the young person an opportunity for self-expression and possibly opens the door to healing experiences.
- Promote as much mastery and self-help as possible—involve people in their own care.

- A calm environment is a safe environment. No matter how stressed you become, lower the tension in the room to avoid triggering a traumatic memory or creating a perceived threat to safety.
- A traumatized individual may need more physical space. Any sudden moves can be misinterpreted as an attack; an encroachment on personal space can trigger a memory of being trapped.
- Body language is critical to maintaining a sense of safety. Traumatized youth will react to being judged and are hypervigilant to any perceived threat.
- Traumatized youth will often react before thinking about consequences, largely because the part of their brain that fires in response to threat reacts instantly. Activation of the reasoning, judging, and evaluating parts of the brain happens later and only then may the young person be able to inhibit their instantaneous reactions, but by that time it may be too late. In any situation where the young person is frightened, upset, or angry, it is better to create a safe space where the youth can retreat and take the time needed to calm down.

Preventing Re-traumatization

We must look at our practices and consider whether our actions could inadvertently trigger youth to become "reactive." Remember, this reactivity was hardwired as a survival mechanism in response to past trauma; triggers can occur any time an interaction reminds a youth of loss of control, shame, or powerlessness. The reactivity is triggered because the teen is hypervigilant to danger.

Triggers can include

- Invasion of body space
- Behaviors perceived as rude, dismissive, or aggressive
- Inflexible rules that can be overinterpreted as attempts at control
- Questions that can be viewed as intrusive, or that are asked before trust is established

When looking at these triggers, it becomes clearer why a staff that treats ALL youth uniformly in a respectful, calm, welcoming manner sets the tone for a trauma-informed setting.

Case 1

Sixteen-year-old Lisa states that guys have noticed her for quite some time. She has had many boyfriends, but does not stay in a relationship very long; perhaps because she has a difficult time forgiving and an even more difficult time controlling her anger. Behind the attitude, we find a young woman who skipped her childhood. Life dealt her some traumatic blows.

She is bright and could excel at any school, but she has bounced between schools because of altercations with students or faculty. Despite anger-management classes, psychotherapy, and medication, she remains volatile. She has insight and verbalizes when she is angrier than usual so people can leave her alone.

After being expelled from her previous school, she came to a second-chance school to get her diploma. She tends to be on edge most of the time and is easily set off. She has shared that she has a hard time controlling her emotions when "irked." She defined "irk" as someone standing over you or continually "nagging" without giving you needed space. While the details of Lisa's life are not known, it is evident she has major struggles with her emotions and respect for authority.

One day she stormed out of her classroom after her advisor (teacher) expressed frustration with her inattention and asked her to regain focus. Lisa went to the resilience specialist's office. She was given space and silence, letting her vent for a minute until she sat down, signaling that her emotional burst was subsiding. The resilience specialist knelt

down, taking a "one down" position, and told her she was in a safe space and that no one would harm or bother her. She had the freedom to be silent or speak. When asked if she wanted to talk about what was going on, she said no. At this point she uncrossed her arms and relaxed her shoulders a bit and her leg stopped shaking. The resilience specialist reaffirmed that she could be silent, but suggested that he ask her questions to which she could nod yes or no.

"Are you upset about something relating to your friends?" She said no. The resilience specialist asked a few similar questions, and then asked a question he knew would get a verbal response. *"Are you pregnant?"* She said resoundingly, *"Hell NO!"* and they both laughed.

At that point she opened up and shared what set her off in her classroom. The resilience specialist worked through that situation and rephrased it back to her to reinforce that she was really heard. She was calmly told that her anger and her reactions went beyond the norm, being angry is not bad but what we do when we are angry can cause problems. She nodded in approval. She was told that it appeared her anger was deeply seated and that she needed to find the source because no matter how much therapy or anger management she received, without dealing with the source she would not overcome or properly manage it. She was told that he would be there when she was ready. She gave a longing look that suggested she was ready then and confirmed it with a nod.

The resilience specialist gently proceeded using trial and error. *"Was the source a recent experience?"* She shook her head no. *"Is it your relationship with your mother?"* She was silent. *"Could it be your father?"* Tears began to roll down her cheek. The resilience specialist stated, *"It seems to me, Lisa, that your tears confirm that you don't have the relationship with him you desire. Has he ever hurt you?" "No." "Are you angry at him for not being around, miss him, and wish things were different?"* She cried inconsolably, ran out of the office and out of the school.

Sometimes pain is a by-product of the process of finding the source of emotional anguish. The resilience specialist later spoke with her and her stepfather to confirm she was all right. When the resilience specialist met with Lisa and her mother the next week, Lisa stated, *"Mom, no one has done what he did. He helped me identify the source of my anger. Now I can deal with it."*

Since then, Lisa has had some ups and downs, but has proven to be an engaged student. Her trauma is not healed, but the foundation has been set for the recovery process to begin. It began with discussing what had been "undiscussable." This can only work when trust is in place and the youth is empowered to set the pace.

Case 2

I am a resilience specialist in a school. One day I was walking up a flight of stairs in the school when I heard loud, angry voices. As I got to the top of the steps, I looked up and saw a young man, Rodney, whom I have known to be playful, easy to talk with, and energetic, walking toward me while, at the same time, turning back to the classroom he had just exited, yelling at someone. I heard his advisor telling him to lower his voice and instructing him to walk away while, at the same time, trying to control other students who had gathered around the entrance to her class, eager to witness the fireworks.

I could tell that Rodney needed a way of getting away from the scene without losing face, since he was still being taunted by the other students standing behind the advisor. Using the excuse that I needed his help with something, I quickly walked him into my office and closed the door. He was still breathing hard when we arrived in the room, his head hung low, shoulders slumped, fists clenched. He looked defeated but ready to fight. His thoughts seemed to be flying around faster than he could get them out.

He said, *"Mr Jones, I don't know what happened. That girl Carol came at me and I didn't start anything, but I'm not going to stay shut!"*

His speech was high and fast and his breathing rapid. *"It's okay,"* I responded, keeping my voice even while making sure to give him space. *"Let's take a couple of really deep, slow breaths and then we can talk about this."*

He leaned back against my door his body was loosened, but his gaze was still focused on the floor. A moment or 2 passed, then he began again. *"I'm gonna leave, Mr Jones. I didn't do anything wrong. She came at me in group and she came in snapping. I was just standing off to the side where I always do."*

His voice this time was more even, his breathing had calmed, he raised his head, and our eyes met. *"I hear you,"* I started, *"so when she came back in what happened next?"*

"We were finishing group when she came back," he said.

Then she said, *"All I know is, you need to sit down with your fake shoes."*

"I was stunned," Rodney said, *"and then everyone in the class started adding their two cents."*

"Okay," I said, *"then what happened?"*

Rodney cracked a smile. *"I might have said a few bad words in there."* We both smiled.

Suspecting that there might be a little more between these 2 students than he had told me about thus far, I asked if they had any past issues.

"No, I mean we don't talk to each other," Rodney declared. *"I try to stay basically to myself. I'm just here to get my education and that's it."*

Again sadness entered into his words, *"I'm gonna go, Mr Jones."*

"Why would you do that?" I asked. He looked up. I said, *"You said yourself you are here to get your education, your diploma, and all the positive things that both will bring. If you leave, you put that at risk; if you choose to stay, we can work through this and nothing is lost."*

At this point, another student who I had worked with, Bill, entered and began explaining how he had gone through similar problems. *"You can't let other people take your future away,"* Bill told Rodney. *"If you're about getting your education, then you can't let small things stand in your way."* Rodney stood with his head up, his eyes moving back and forth from me to Bill, nodding in agreement.

I began again, *"You said she came in when group was ending. Where had she been?"*

He responded, *"She was meeting with the teacher for like a half hour, and she came back looking mad as ever."*

"Do you think she got bad news?" I asked.

"Yeah probably, because when she came in she slammed her stuff down and everybody looked up."

"Do you think she might have been taking out her anger on you because you were standing and probably caught her attention first?"

He nodded and said, *"Yeah, you're probably right. She might have been upset about something else."* He paused for a moment. *"If I could do it over again, I would have just talked to her later, like one on one."*

Bing! It was like a light went on in his head and he understood it was never about him or his shoes.

"How do you feel? Would you like to join your class?" I asked.

"Yeah. I wanna go back."

The 3 of us started walking back toward his classroom. There were some last-minute words of encouragement from his schoolmate. *"Don't let the little things stop you. You're here for a reason!"* Bill said. Peers can be powerful forces of healing.

Trauma-Informed Strategies

The techniques presented throughout *Reaching Teens* are presented as strength-based or resilience-building strategies, but are also trauma-informed. The following chapters are a representative, but not exhaustive, sample of those that include trauma-informed communication or behavioral-change techniques.

"Who's the Expert? Terms of Engagement in Adolescent Care" (Chapter 4) reinforces that youth need to have relationships with adults who understand that teens must maintain control over their decisions.

"Setting the Stage for a Trustworthy Relationship" (Chapter 14) reinforces that trust needs to be earned. This is a critical point for youth who have not experienced adults as trustworthy.

"Body Language" (Chapter 15) speaks to how low expectations and aggressive versus helpful intention can be conveyed through body language.

"Boundaries" (Chapter 20) covers the importance of not overpromising. Youth who have a history of being let down by adults are particularly vulnerable to broken expectations.

"De-escalation and Crisis Management When a Youth Is 'Acting Out'" (Chapter 23) discusses how to lower the temperature during rising conflicts. The importance of giving space and respectful listening is emphasized. 23.0

"Addressing Demoralization: Eliciting and Reflecting Strengths" (Chapter 25) covers how to listen deeply so that youth are able to display their better sides. When existing strengths are reflected back to the teen, it can be a pivotal step to breaking the cycle of disempowerment and hopelessness. 25.0.2

"Health Realization—Accessing a Higher State of Mind No Matter What" (Chapter 27) is rooted in the belief that all people, no matter how traumatized, have the inherent ability to self-right and heal.

"Gaining a Sense of Control—One Step at a Time" (Chapter 29) allows an individual to move past the sense of disempowerment associated with seeing problems as insurmountable. It helps youth break problems into manageable components.

"Helping Adolescents Own Their Solutions" (Chapter 28) discusses how to empower youth to reach their own conclusions. Specifically, it recognizes that, because youth in crisis cannot think abstractly, a lecture can be experienced as condescending, even offensive. The chapter offers alternative communications strategies.

"Stress Management and Coping" (Chapter 31) offers strategies for healing, including safe emotional expression and healthy disengagement strategies.

"Mindfulness Practice for Resilience and Managing Stress and Pain" (Chapter 32) offers techniques that allow an individual to live in the present rather than being trapped in the past.

"Somatic Symptoms" (Chapter 44) discusses how to work with youth whose stress has been internalized into physical symptoms.

"Grief" (Chapter 45) discusses how to help young people recover from pain and loss.

"Emotional, Physical, and Sexual Abuse" (Chapter 57) covers assessing and supporting youth who have experienced these profound traumas.

"Healer, Heal Thyself: Self-care for the Caregiver" (Chapter 67) recognizes that, as we are exposed to others' unimaginable pain, we must stem the forces that create a "protective" shell between us and youth, and us and our emotions. To remain emotionally intelligent, we must first care for ourselves.

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•• Group Learning and Discussion ••

1. Discuss some of the adverse childhood experiences you have seen in your practice. Then discuss how youth with those experiences generally behave.
2. Reflect on how you respond to the reactivity of traumatized youth. Are youth given the calm space to regain their footing? Might they feel controlled? Shamed?
3. Reflect on whether you routinely accept diagnoses and labels of youth who often "act out." How might these labels create unconscious biases in the way you serve these adolescents? (See Chapter 21.)
4. Reflect on whether anything in your setting might inadvertently re-traumatize adolescents. If so, what action steps could be taken in your practice setting?
5. Recognizing your own human limitations, what steps can you take to control your own reactions so that you can be "radically calm" amidst chaos?
6. Read Chapter 23. Break into pairs and apply those strategies to a case your practice has recently seen.

Continuing Education

If you are applying for continuing education credits, a test is available online. For more details, visit www.aap.org/reachingteens.

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Suggested Reading

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Related Video Content

22.0 Trauma-Informed Practice: Working With Youth Who Have Suffered Adverse Experiences. El Centro staff, Covenant House staff.

22.0.1 Trauma-Informed Practice Part 1: What Happens to Youth From Traumatizing Environments? El Centro staff, Covenant House staff.

22.0.2 Trauma-Informed Practice Part 2: The Positive Force That Traumatized Youth Bring to the World. El Centro staff, Covenant House staff.

22.0.3 Trauma-Informed Practice Part 3: Essential Elements of a Healing Environment. El Centro staff, Covenant House staff.

23.0 De-escalation and Crisis Management: Wisdom and Strategies From Professionals Who Serve Youth Who Often Act Out Their Frustrations. Youth-serving agencies.

23.2 Why Youth Act Out...and What They Really Need. YouthBuild youth.

25.0.2 Addressing Demoralization: Eliciting and Reflecting Strengths. Ginsburg.

25.9 Behaviors Must Be Seen in the Context of the Lives Youth Have Needed to Navigate. Auerswald.

57.2 The Making of a Girl. The GEMS Project.

Related Handout/Supplementary Material

Hidden Among Us: Sexually Exploited and Trafficked Youth